United Nations E/ICEF/2008/24

Economic and Social Council

Distr.: General
21 July 2008

Original: English

For discussion

United Nations Children's Fund
Executive Board
Second regular session 2008
15-18 September 2008
Item 8 of the provisional agenda*

Recent meetings of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Programme Coordinating Board (PCB): recommendations and decisions of relevance to UNICEF**

Introduction

1. The current report focuses on the implementation of decisions from the 20th and 21st meetings of the Programme Coordinating Board (PCB) of the Joint United Nations Programme on HIV/AIDS (UNAIDS), held in June and December 2007 respectively, as well as on the plans for follow-up on the decisions of the 22nd PCB meeting, held in April 2008. Issues discussed at these recent PCB meetings that are of relevance to UNICEF included:

(a) The status of implementation of the Global Task Team (GTT) recommendations and follow-up to the GTT independent assessment;

(b) The collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria;

(c) The gender sensitivity of AIDS responses;

(d) The cycle of UNAIDS unified budget and workplan;

(e) The Second Independent Evaluation of UNAIDS;

(f) The process for nomination of the Executive Director of UNAIDS.

* E/ICEF/2008/16.

** Submission of this document was delayed because of the need for internal consultation.

08-43161 (E) 110808

I. The status of implementation of the Global Task Team (GTT) recommendations and follow-up to the GTT independent assessment

2. In accordance with the UNAIDS Technical Support Division of Labour, the areas of responsibility of UNICEF to support universal access to HIV prevention, treatment, care and support are reflected within the medium-term strategic plan (MTSP) for 2006–2009 and the four programmatic areas of the campaign *Unite for Children, Unite against AIDS*: (a) prevention of mother-to-child transmission (PMTCT); (b) provision of paediatric treatment; (c) prevention of HIV among adolescents; and (d) protection and support for children affected by HIV and AIDS. Across each of the four programmatic areas, UNICEF is working to provide leadership, advocate on behalf of children, meet supply and resource needs, convene stakeholders, track progress and build partnerships at all levels.

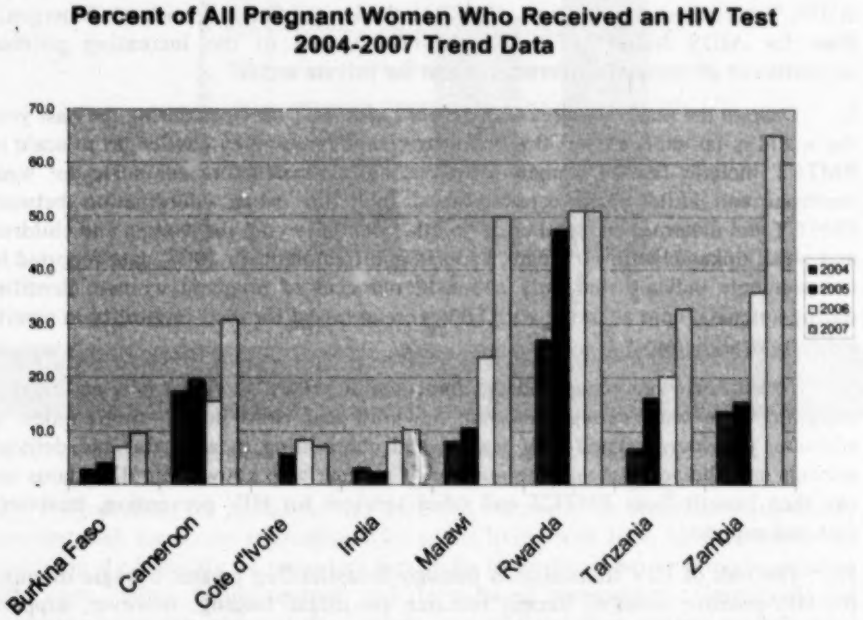
3. In the first half of 2008, UNICEF, UNAIDS and the World Health Organization (WHO) published the *Children and AIDS: Second stocktaking report* (April 2008) and the progress report *Towards Universal Access — Scaling up priority HIV/AIDS interventions in the health sector* (June 2008). For the first time, the 2008 progress report on universal access has a chapter on women and children. This section incorporates data collected by the expanded Inter-Agency Task Team (IATT) on prevention of HIV infection in pregnant women, mothers and their children, to track progress on PMTCT and *paediatric HIV care, support and treatment*. Both reports show encouraging trends, as well as ongoing challenges, in meeting the targets for Millennium Development Goal 6 and the 2010 goal of universal access to HIV prevention, treatment, care and support.

4. Most countries are making substantial progress towards PMTCT. At the end of 2007, an estimated 33 per cent of pregnant women living with HIV received antiretroviral prophylaxis to prevent transmission to their children, a substantial increase from only 10 per cent in 2004. The most significant expansion was in sub-Saharan Africa, which includes 12 countries with the highest number of HIV-positive pregnant women. In 2007, nearly all of the 20 countries with the highest number of pregnant women living with HIV had developed national plans for scaling up PMTCT and HIV treatment, care and support for children. By the end of 2007, 20 countries were on track to reach the United Nations General Assembly target of 80-per cent access by 2010.

5. UNICEF provided support to PMTCT activities in 97 countries in 2007, compared to 90 in 2005. This included technical assistance in policy and planning, communication, training and the dissemination of information on the procurement of drugs and other supplies, as well as the dissemination of the *Guidance on Global Scale-up of the Prevention of Mother-to-Child Transmission of HIV*, adopted at the December 2007 High-Level Global Partners Forum by international stakeholders and representatives from 30 countries implementing PMTCT and paediatric AIDS. One mechanism that has been useful in accelerating country-level efforts is the provision of technical support through the joint technical missions, initiated in 2004 and coordinated by the Inter-Agency Task Team (IATT) on prevention of HIV infection in pregnant women, mothers and their children. Between 2005 and 2007, the IATT conducted 13 joint technical missions across sub-Saharan African and India to review the status of programme implementation, identify bottlenecks and make recommendations on strategic programming in order to accelerate scaling-up.

UNICEF also commissioned a review covering experiences from eight joint missions in Burkina Faso, Cameroon, Côte d'Ivoire, India, Malawi, Rwanda, Tanzania and Zambia. As Figure 1 indicates, most countries surveyed have demonstrated important progress in scaling-up coverage of PMTCT services.

Figure 1
Percentage of pregnant women tested for HIV in seven countries benefiting from IATT Joint Technical Missions in 2004-2007



6. In November 2007, UNICEF and UNITAID,[1] in collaboration with WHO, launched a joint initiative to help scale up national programmes to prevent mother-to-child transmission of HIV. This joint initiative will help accelerate the scaling-up of HIV testing and counselling by health workers in antenatal, maternal and postpartum health services, broaden the provision of antiretroviral therapy to women and their newborns, and increase early access to paediatric HIV treatment for young HIV-infected infants. On an initial basis, eight countries are set to benefit from this initiative: Burkina Faso, Cameroon, Côte d'Ivoire, India, Malawi, Rwanda, Tanzania and Zambia. Under the agreement, UNITAID will fund HIV diagnostics, antiretroviral medicines and antibiotics for patients in the target countries for a period of up to 24 months, for a total amount of $21 million. UNICEF participates as follows:

[1] Launched on 19 September 2006, UNITAID is an international drug purchase facility, which aims to fill a critical gap in the global health financing landscape. Its innovative model of financing seeks to reduce prices of quality drugs and diagnostics and accelerate their availability for people primarily in developing countries. Initiated by Brazil, Chile, France, Norway and the United Kingdom, UNITADS now has 27 member countries, 19 of which are in Africa.

(a) Contribute policy and operational guidance, local capacity building and technical assistance for planning, implementation, monitoring and evaluation;

(b) Use its procurement experience to access high-quality products at the lowest prices;

(c) Provide in-country support for the efforts of Governments to effectively distribute medicines and diagnostics.

7. The progress observed in PMTCT implementation to date owes a great deal to support from a growing number of stakeholders, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the United States President's Emergency Plan for AIDS Relief (PEPFAR), UNITAID, and to the increasing political commitment of national Governments and the private sector.

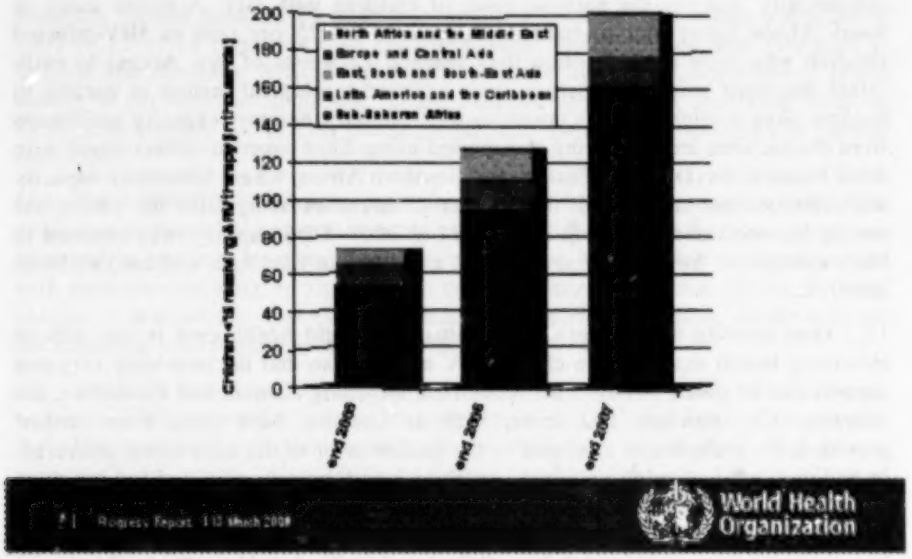
8. Despite the marked increase in access to PMTCT services during the past year, the world is far short of the 80-per-cent coverage target. Key challenges to scale up PMTCT include limited human resources and infrastructure for scale-up; weak maternal and child health-care services, including weak coordination between PMTCT and maternal neonatal child health, poor follow-up for women and children, and weak linkages with HIV care, support and treatment. In 2007, data reported by Governments indicate that only about 12 per cent of pregnant women identified during antenatal care as living with HIV were assessed for their eligibility to receive antiretroviral therapy.

9. To optimize outcomes and the impact of PMTCT services, it is essential to integrate them with strong maternal, newborn and child health programmes. In addition, provider-initiated HIV testing and counselling in antenatal and delivery settings have helped increase the number of women who know their HIV status and can then benefit from PMTCT and other services for HIV prevention, treatment, care and support.

10. The risk of HIV transmission through breastfeeding creates a tragic dilemma for HIV-positive women. Recent research on infant feeding, however, supports exclusive breastfeeding by HIV-infected women for the first six months of their infants' lives, unless replacement feeding is affordable, feasible, acceptable, safe and sustainable.

11. The majority of children living with HIV can be saved by timely administration of paediatric antiretroviral treatment and cotrimoxazole, a low cost antibiotic that has been shown to have a positive impact on HIV-infected children's survival. In low- and middle-income countries, the number of children receiving antiretroviral treatment increased from about 75,000 in 2005 to almost 200,000 in 2007. This represents a 2.6-fold increase between 2005 and 2007 (Figure 2).

Figure 2
Number of children receiving antiretroviral therapy in low- and middle-income countries, 2005-2007



Source: World Health Organization, *Progress Report*, Geneva, 13 March 2008.

12. Programming for paediatric HIV care and treatment has benefited significantly from the push for access to treatment for adults living with HIV. Most countries are expanding the capacity of providers for adults to enable them to provide children with care, using family-centred and team-based approaches. Continued and increasing advocacy, reduced drug prices, use of fixed-dose generic antiretroviral combinations and better forecasting of paediatric drug needs have made it possible for many more countries to access antiretroviral therapy for children. Until recently, access to paediatric antiretroviral treatment was limited by a lack of antiretroviral drugs in formulations appropriate for use of children. In 2007, the United States Food and Drug Administration and the WHO prequalification programme approved a new three-in-one generic antiretroviral drug combination for children. The drugs are now procured by Governments through the UNICEF Supply Division and PEPFAR, but more efforts are needed to get affordable and better paediatric combinations prequalified and registered.

13. Access to HIV diagnosis, antiretroviral treatment and cotrimoxazole among young children is still very low. In 2007, some 77 countries (71 per cent of all reporting low- and middle-income countries) provided data on early testing of infants and young children. Of the 715,000 infants born to women living with HIV in 2007 in these countries, only 8 per cent (54,900) were tested within the first two months of birth. This is due to a variety of constraints, including lack of testing facilities for young children; perceptions of stigma and discrimination among parents and caregivers; lack of specific knowledge of paediatric AIDS amongst health workers; weak delivery capacity and communication; and national

programmes that continue to give inadequate emphasis to the needs of children. The inability of many healthcare systems to track children's HIV status, even when mothers are known to be infected with HIV, is a missed opportunity.

14. Early diagnosis of HIV and treatment within the first few months of life can dramatically improve the survival rates of children with HIV. A recent study in South Africa found that mortality was reduced by 75 per cent in HIV-infected children who were treated before they reached 12 weeks of age. Access to early infant diagnosis using polymerase chain reaction virological testing is starting to become more available, and in countries with limited laboratory capacity, specimens from distant sites are now being transported using filter paper to collect blood with dried blood spots (DBS). In Eastern and Southern Africa, where laboratory capacity and infrastructure are limited, the number of countries using DBS for virological testing has increased from 6 in 2005 to 11 in 2007. DBS capacity was reported in two countries in West and Central Africa, and three in East Asia and the Pacific in 2007.

15. Documenting the mother's HIV status on a child health card is one way of informing health workers of a child's HIV exposure so that the necessary care and support can be given. A number of countries, including Zambia and Zimbabwe, are adopting this approach, and some, such as Lesotho, have gone even further, providing the child health care card to the mother prior to the baby being delivered. In addition, strengthening maternal and child health programmes and linking them to HIV care and treatment programmes will improve the survival of all children, including those living with HIV. Performance measurement and quality improvement systems are tools that can be used to increase the uptake of essential interventions and ensure delivery of a comprehensive package of care that addresses the full breadth of child survival priorities. HIVQUAL[2] is now being adapted for use in health systems around the world. It permits health workers to generate ongoing data about the performance of health facilities so that problems can be identified and remedied quickly and services constantly improved. In collaboration with the United States Centers for Disease Control and Prevention, the Government of Thailand piloted HIVQUAL in 12 hospitals in 2003, which is now the standard method for monitoring quality of HIV care throughout the healthcare system, including paediatric treatment. HIVQUAL has also been implemented in Mozambique, Namibia and Nigeria, as well as in Guyana and Uganda, where it is being piloted for broader paediatric HIV care.

16. The value of antiretroviral drugs procured by UNICEF almost doubled, from $37 million in 2006 to nearly $66 million in 2007. Substantial price decreases have helped to increase the number of treatment packs delivered to over 5 million people in 2007. The value of HIV test kits procured by UNICEF increased from $7.3 million in 2006 to $11 million in 2007. A similar increase took place in HIV/AIDS-related diagnostic equipment, reagents and consumables, which reached over $5 million.

17. Prevention of HIV transmission among young people and adolescents is crucial to reaching the targets set by the United Nations General Assembly special session on HIV/AIDS and the Millennium Development Goals. Comprehensive and

[2] HIVQUAL is a framework for quality management of care to persons living with HIV that was developed in New York State in the United States of America. It has been adopted by a number of countries.

correct knowledge about HIV and AIDS is estimated to have increased by at least 10 per cent among young women in 17 countries and among young men in five countries. The United Nations Secretary-General's 2008 report, 'Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals', indicates that HIV prevalence among young pregnant women aged 15-24 attending antenatal clinics has declined since 2000-2001 in 12 of 15 countries with sufficient data.[3] These include nine countries in Eastern and Southern Africa, the region with the highest HIV-prevalence levels among adults and young people. These declines seem to be consistent with an increase in condom use among young people, and there is some evidence of partner reduction.

18. More than 70 developing countries and territories now mandate life skills education with an HIV-prevention component in national school curricula. However, more works needs to be done to address stigma and discrimination related to HIV, with strategies drawing on rights-based communication for social and behavioural change. It is also clear that efforts to reach adolescents and young people who are not attending school must be strengthened.

19. UNICEF continues to contribute to the expansion of youth-friendly health service (YFHS) networks, notably in countries of Central and Eastern Europe and the Commonwealth of Independent States. Voluntary counselling and testing networks were expanded in African countries, such as Ethiopia, Lesotho, Malawi and Mozambique. The successful 2007 HIV/AIDS campaign for young people in Timor-Leste was based on decentralized planning, peer-to-peer message dissemination, and strong local ownership. However, the establishment and expansion of YFHS within national health systems continues to be a challenge, given the limited capacities in many cases. Youth centres providing information and peer-to-peer counselling on HIV/AIDS were established and supported with UNICEF assistance in many countries, including Burundi, the Occupied Palestinian Territory, the Russian Federation and Uganda, where 34 youth information centres, established over the last five years, are raising awareness on HIV/AIDS, sexually transmitted infections and drug-use prevention. In all regions, UNICEF supported HIV/AIDS awareness-raising campaigns targeting young people through sport activities.

20. In February 2008, the Deputy Executive Directors of the UNAIDS Secretariat and Cosponsors met for the second time to discuss the coordination of HIV interventions targeting young people. They agreed to develop specific time-bound actions, and defined accountability to ensure a more harmonized and coherent joint United Nations response in support of the prevention, treatment and care of HIV among young people. As a result, the Global Inter-Agency Task Team on HIV and Young People was expanded to partners beyond the United Nations, and a more explicit division of labour on young people within the existing UNAIDS Technical Support Division of Labour was developed. In addition, the IATT developed a series of guidance briefs to help the United Nations country teams and United Nations theme groups on AIDS provide guidance to their staff, governments, development partners, civil society and other implementing partners on the specific actions that need to be in place to respond effectively to HIV among young people.

[3] The 12 countries are the Bahamas, Botswana, Burkina Faso, Burundi, Côte d'Ivoire, Kenya, Malawi, Namibia, Rwanda, Swaziland, the United Republic of Tanzania and Zimbabwe.

21. Still, more needs to be done. By the end of 2007, young people aged 15–24 accounted for about 40 per cent of all new HIV infections and 5.4 million young men and women are living with HIV. Only in nine low- and middle-income countries did 50 per cent or more of young people have comprehensive knowledge on HIV and AIDS.

22. Better evidence-based information on the behaviour of young people and adolescents, especially those most at risk, is urgently needed in order to improve and target HIV-prevention efforts. Survey data need to be disaggregated by age and sex, and by marital status when possible. In addition, comprehensive responses to preventing HIV in adolescents and young people need to be promoted, supported and monitored — with the meaningful participation of young people, as part of national HIV frameworks. National and subnational priorities for HIV prevention should also be established according to the different types of epidemics and different vulnerabilities and risks among adolescents and young people. In high-prevalence settings with large populations of adolescents in school, the education sector needs to address HIV prevention — including the risks posed by complex sexual networks (multiple concurrent partnerships and intergenerational sex) — through formal curricula and other means. Young people everywhere need accurate and relevant information about sexual and reproductive health and HIV transmission, as well as opportunities to build risk-reduction skills. They also need access to appropriate HIV-prevention services, including voluntary counselling and testing, harm reduction, sexual and reproductive health services, PMTCT and male circumcision, and to condoms.

23. The estimated number of children affected by AIDS, who have lost one or both parents to AIDS-related infections, grew from about 6 million in 2000 to about 15 million in 2005. At the end of 2007, 24 countries in the world, including 21 in sub-Saharan Africa, had completed specific national plans of action for children affected by AIDS, and 10 countries in the world, including nine in sub-Saharan Africa, had plans in process. Orphans aged 10–14 years who have lost both parents are still less likely to be in school than children living with at least one parent, but the disparity between the two groups has declined in some countries. This decline is due in part to UNICEF-promoted interventions such as the abolition of school fees and the provision of cash transfers as part of a more comprehensive social protection approach.

24. National plans of action for children affected by AIDS were finalized or approved in several countries during 2007, including Burundi, Namibia, Rwanda and the United Republic of Tanzania. In addition, UNICEF continued to promote the availability of information for policy makers and implementation through a wide range of studies, including a national situation analysis on children affected by AIDS in Rwanda; a review of two pilot cash transfer schemes in Malawi and Zambia; an impact assessment of caregiver training in Swaziland; an analysis of the cash transfer system for children affected by AIDS in Ghana; and capacity assessments of non-governmental organization (NGO) service providers. With UNICEF support, national registration systems or databases for children affected by AIDS were strengthened in Botswana, Lesotho, Namibia, Sierra Leone, Swaziland and other countries. UNICEF also continued to assist efforts to strengthen community capacity to provide care and support for children affected by AIDS. In Malawi and South Africa, for example, UNICEF provided assistance to help to institutionalize community child-care centres. In Namibia, Swaziland and

Zimbabwe, UNICEF supported training for a range of care-providing groups, including faith-based organizations and grandmothers' groups.

25. In Zimbabwe, an estimated 400,000 children affected by AIDS will be reached with vital services through a fund totalling $85 million, pooled in from six donor agencies, under the management of UNICEF. The GFATM continues to make available substantial new resources for programmes focusing on children affected by AIDS, while faith-based organizations, such as the Church Alliance for Orphans in Namibia, continue to be important partners in implementation. However, in Uganda, slow progress in implementation of programmes of children affected by AIDS funded by the GFATM threatened further disbursements. The situation is being addressed through a newly established Civil Society Fund and stronger technical support to the Government.

26. Stigma and discrimination against children affected by AIDS continue to be major obstacles and must be addressed in all aspects of the response to the epidemic. In areas of low prevalence and concentrated epidemics, only a small proportion of children are affected by AIDS. But these children and their families are particularly likely to face discrimination, especially where parents are already stigmatized because of their perceived behaviour. Recent research in Bangladesh, India, Nepal and Pakistan shows how HIV-related stigma and discrimination prevent children from receiving basic social services and sometimes lead to long-term institutionalization and denial of parental service.

27. Research on the effects of AIDS in Africa has led to an opinion shift on the meaning of vulnerability in the context of a generalized epidemic. Children affected by AIDS are more likely than other children to fall behind in school, and they tend to live in poorer households. Policy makers are finding that it often makes sense to support AIDS-affected communities by improving services for all vulnerable children — including those who are in poor health, out of school, burdened with excessive labour, extremely poor or stigmatized — regardless of their orphan or HIV status.

28. Laws, policies and services that support families and communities in looking after orphans will greatly improve the well-being of these children. Support for children affected by AIDS should not exclude other equally vulnerable children from accessing essential services; programme beneficiaries should not be identified by orphan status only.

29. The above findings and lessons learned have a number of implications for the work of UNICEF at the country level. Throughout 2008, technical support to country-level processes will remain the top priority within the UNICEF extended cluster approach as well as for established joint mechanisms such as the IATTs. For PMTCT and paediatric HIV treatment, specific focus will be placed on supporting the strengthening of laboratory capacity, roll-out of early infant diagnosis of HIV infection and cotrimoxazole prophylaxis within the context of improved health service delivery systems, as well as promoting greater access to antiretroviral drugs for HIV-positive pregnant women in need. In the area of prevention, UNICEF will support more qualitative research on the determinants of behavioural change among adolescents and young people, and on the social mobilization necessary to support such changes. More efforts are further needed to ensure that adolescents and young people, including those living with HIV, systematically participate in the design, implementation and monitoring of HIV-prevention programmes. In the area of

children affected by AIDS, the focus of UNICEF will be on supporting the finalization and consolidation of studies, reviews and analyses being conducted by various partners and the IATT working groups. The compiled reports will form the basis for the Global Partners Forum discussions scheduled for October 2008. UNICEF regional offices in West and Central Africa, the Eastern Asia and the Pacific, and South Asia have developed strategic plans and frameworks, which — in addition to outlining key investment areas in PMTCT, paediatric care, children affected by HIV and AIDS, as well as adolescent and humanitarian programming — also provide the strategies underpinning the workplan activities. These guiding strategies include: (a) support country offices to leverage opportunities; (b) build national technical capacity; review or develop national documents, such as scale-up plans, policies, procedures and training curricula; (c) scale up coverage; and (d) broker new partnerships.

30. At the heart of all of these strategies is a dual approach: combining our expertise and commitment to decentralised and locally-responsive interventions with an increasingly important role at the national level to support central governments in scaling up. This dual approach recognises the fact that UNICEF is one among many partners in the fight against HIV and AIDS, and with smaller resources by comparison. The most important strength of UNICEF is adding value to the overall national response to the epidemic. It does this best by identifying and leveraging existing opportunities at the national level that can have profound and sustainable impacts within local districts. Working at multiple levels has other advantages. First, it maximizes existing national level opportunities, increasing its cost-effectiveness, thus allowing UNICEF to address multiple issues simultaneously. At the same time, countries choosing to focus on only one or two issues of the four Ps can use the district level to develop expertise and credibility before expanding and scaling up. This balance between working nationally and showing results within districts is a central feature of our future work.

31. The roll-out of the campaign *Unite for Children, Unite against AIDS* during 2006 highlighted the need for UNICEF to increase its own internal capacity to meet the goals of the campaign. UNICEF needs to both increase the number of staff involved and ensure that new staff members have expertise that lends itself to the achievement of the goals, which cut across all of the organization's normal areas of expertise and intervention, but often require a somewhat different focus. Organizational capacity will be required in the future to influence national policies that affect child and adolescent policies in all of the areas addressed by *Unite for Children, Unite against AIDS*. It is also imperative that UNICEF improve its capacity to document promising country-level experiences and communicate this information to countries, potential donors, and others. This step has the potential both to leverage further resources and to improve organizational capacity to influence national policies that affect child and adolescent policies in all of the areas covered by the campaign.

32. There are now 89 countries that have established joint United Nations teams on AIDS, and about 56 of these teams report having developed a joint programme of support. There are differences on the definition of what constitutes a joint programme of support. To better support joint United Nations teams on AIDS, UNAIDS developed and disseminated a second guidance paper on joint programmes in early 2008, clarifying aspects of the first guidance paper that presented challenges in implementation, based on reports from the field. The UNAIDS

Secretariat and Cosponsors also supported the development of a toolkit addressing a wide spectrum of needs of the United Nations system for establishing and activating coordination mechanisms and implementing joint programmes of support on AIDS. The emphasis is on explaining and applying guidance concepts, building skills and encouraging collaboration among United Nations system staff and partners.

33. UNICEF is supporting joint teams on AIDS through technical support at the country level. In East and Southern Africa, technical assistance to joint teams on AIDS is part of the workplan for the regional inter-agency HIV prevention working group. Quality assurance for the prevention component of the joint teams' workplans is an on-going process. The annual workplans are reviewed during the regional advisor's joint or individual missions: progress, constraints and support are discussed and follow-up issues are then flagged. Follow-up technical assistance is also planned with the prevention group of the teams. At the regional level, the interagency prevention group reviews progress made in supporting the joint teams. In India, the Joint United Nations Team on AIDS is contributing to a Joint United Nations Programme of Support to provide technical assistance in the area of strategic planning and capacity building; care and support for women and children; and prevention among young people with high risk behaviour. UNDP, UNICEF and the United Nations Office on Drugs and Crime take a lead role in each of the areas mentioned above and implement them in four north-eastern states, namely, Manipur, Meghalaya, Mizoram and Nagaland.

34. Lessons learned from the Joint United Nations Teams on AIDS underpin the importance to capture the needs of countries in setting up joint teams and to review their progress. Initial guidelines allowed different countries to experiment with different approaches, yet all teams need to take into account minimal requirements. Cosponsors' headquarters should further articulate the roles and responsibilities of the heads of country offices in setting up joint teams, and the respective regional directors' teams could reinforce this message. The development and implementation of Joint Programmes of Support are intrinsically linked to the development and review of national strategic plans, including operational plans, and to the role the United Nations system can play in assisting in the development of technical plans of support at the country level.

II. Strengthened collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria

35. At its 21st meeting, held in June 2007, the UNAIDS Programme Coordinating Board decided to:

(a) Request UNAIDS to work with the Global Fund to Fight AIDS, Tuberculosis and Malaria to revise and update their Memorandum of Understanding;

(b) Redefine and, in light of the changed landscape, update the areas and modalities of their cooperation;

(c) Present the action taken to their respective boards for approval;

(d) Develop a shared follow-up system for the purposes of accountability.

36. The response to AIDS and its institutional arrangements have evolved since the signing of the first Memorandum of Understanding (MoU). The development of

the new MoU is based on an analysis of the current situation and a clear definition of the complementary roles of UNAIDS and GFATM. Key considerations include working in partnerships to enable country-led ownership; the GFATM growth and development of new policies; increased demand for technical support; better understanding of programmatic bottlenecks; and the role of technical partners in grant development, implementation and evaluation.

37. Within the context of the new MoU, UNAIDS and the GFATM are committed to a partnership that will move towards universal access to prevention, treatment, care and support by 2010; empower inclusive national leadership and ownership, harmonize support to national programs and align financial, monitoring and evaluation processes to increase aid-effectiveness, guide and support global advocacy efforts to ensure high-level political support for a comprehensive response to AIDS.

38. A task team, comprising GFATM, the International Labour Organization (ILO), UNDP, the UNAIDS Secretariat, UNFPA, UNICEF, WHO and the World Bank, developed the new MoU, which the 22nd PCB approved in April 2008. Based on mutual accountability, this new MoU serves as a single umbrella strategic framework to guide the partnership. In addition, the UNAIDS Secretariat and relevant Cosponsors will develop, in partnership with the GFATM, follow-up operational arrangements under this framework. Dr. Peter Piot and Prof. Kazatchkine signed the revised MoU at the HIV/AIDS Implementers Meeting in Kampala, Uganda, in June 2008.

39. Country plans for implementing the MoU will be developed jointly with Cosponsors' country offices and in consultation with selected UNAIDS regional and field staff. All stakeholders will undertake joint advocacy for strong political commitment at all levels. Communication between the GFATM, the UNAIDS Secretariat and Cosponsors will be essential. Mechanisms for improved communication at all levels will be defined in future operational agreements.

40. The GFATM will solicit UNAIDS' support in the process of identifying membership and providing input on content and participation when organizing comprehensive technical briefings. Both partners recognize that the Technical Review Panel (TRP) is an independent body and that the technical review process is subject to policies and procedures specified by the GFATM. Individual Cosponsors will invite members of the TRP to technical briefings, in their capacity as experts, wherever possible.

41. UNAIDS is supporting the development of technically sound and fully costed national strategic plans that are the foundation of the national response. These plans are an already established prerequisite for the applications for the current rounds of proposals, and will form the basis of future national strategic applications of GFATM. UNAIDS, with support from UNICEF, will continue to facilitate the development and validation of national strategic plans, based on scientific evidence and human rights.

42. With this opportunity of greater collaboration, UNICEF will support the country coordinating mechanism and GFATM proposal development process, with the aim of supporting the development of more child-focused grant proposals. UNICEF has also had a number of consultations with the GFATM, and both parties agreed to continue the analytical work on several identified building blocks in the

hope of building on good collaborative processes established in previous rounds and to increase the capacity of UNICEF to leverage a substantial portion of the $2 billion available for Round 8. As such, UNICEF identified eight key countries (Belarus, Cambodia, Côte d'Ivoire, Haiti, Nigeria, Uzbekistan, Zambia and Zimbabwe) where it is focusing on intensified technical support to strengthen proposal development on PMTCT and paediatric AIDS treatment. Another building block is to deal with procurement and supply management, particularly on emerging pooled procurement and in-country capacity building. An additional building block focuses on strategic information and the use of data generated from multiple indicator cluster surveys (MICS) for monitoring and evaluation.

III. Gender sensitivity of AIDS responses

43. After presentation of the requested gender assessments and draft policy guidance to address gender issues in June 2007, the PCB stated at its 20th meeting that it:

> "welcomes the findings of the gender assessments and requests UNAIDS to further develop and finalize the draft guidelines in consultation with Governments, donors, the United Nations system, global HIV initiatives, civil society and all relevant stakeholders, focusing on concrete actions to achieving gender equality and equity in national HIV responses."
>
> And:
>
> "requests that the finalized guidelines be presented to the Programme Coordinating Board at its first meeting in 2008 with a costed action plan for their dissemination and implementation at the country level."

44. In the follow-up to these Programme Coordinating Board decisions, UNDP, the UNAIDS Secretariat and the United Nations Development Fund for Women (UNIFEM) led an extensive consultation process to further develop and finalize the draft policy guidance submitted to the Programme Coordinating Board in June 2007. An emphasis was placed on involving the governments and civil society stakeholders from low- and middle-income countries, including national AIDS commission chairs and members, national AIDS programme staff, civil society organizations involved in programme implementation and advocacy, and staff of gender and women's ministries. UNICEF provided technical assistance in developing the draft policy guidance.

45. The purpose of the guidance is to promote increased and improved action on the intersecting issues of AIDS and gender inequality at the country level, emphasizing three cross-cutting key principles: know the epidemic; ensure that responses are evidence-informed; and root strategies, policies and programmes in human rights. The guidance complements existing gender guidelines and tools by emphasizing the process of strengthening action to address gender equality in AIDS responses. It does not attempt to describe in detail how to intervene in specific thematic areas or sectors, as a wide variety of training materials and tools are already available to guide and support specific interventions. This guidance will support ongoing work of UNICEF on gender and HIV/AIDS at the country level.

46. UNDP, UNIFEM and the UNAIDS Secretariat will develop specific tools to assist countries in planning, programming and implementing interventions in the

context of HIV that address women, girls and gender inequality. Cosponsors, including UNICEF, will support UNDP and partners to conduct pilots of the gender guidance in four countries with differing epidemiological profiles. The outcomes of these pilots will inform the development of the above-mentioned tools. In addition, UNICEF will assist UNDP in establishing an expert group on women, girls and gender inequality, comprising also male members. UNAIDS will report back on progress made at the 23rd PCB meeting.

IV. Cycle of UNAIDS unified budget and workplan

47. A two-year UNAIDS unified budget and workplan (UBW) is currently the main instrument used by UNAIDS to coordinate and operationalize priorities for the United Nations system response to AIDS. The evolution of the UBW as a key instrument for joint programming and budgeting, coordination, accountability and fundraising continued throughout the following biennia: 2004-2005, 2006-2007 and 2008-2009. Over time, the UBW has embraced and guided an ever-growing partnership of cosponsoring organizations, introduced new features and budget categories, became more result-based and aligned itself with global priorities and internationally agreed development goals, including those contained in the Millennium Declaration and the Declaration of Commitment on HIV/AIDS. The UBW is an instrument to boost implementation of harmonized agendas (Global Task Team on Improving AIDS Coordination and UNAIDS Division of Labour) and is considered a good example of United Nations reform in practice. It is a unique and continuously evolving programming and budgeting platform that brings together multiple United Nations entities.

48. To achieve Millennium Development Goal 6 on stopping and reversing the spread of AIDS, the response to the global pandemic requires a long-term approach, with sustained commitment and predictable funding to ensure the most effective AIDS response possible. The long-term approach must be based on an evidence-informed analysis of the epidemic and the response to it, effective synergistic partnerships within UNAIDS as well as between UNAIDS and other key stakeholders in the response, and on strengthened governance and management of UNAIDS. This approach must also promote and nurture a greater sense of ownership and commitment by all stakeholders by providing a longer-term framework for action, with greater understanding of the impact of the response. The case for moving from a two-year to a four-year planning framework is built on the following considerations:

(a) Longer-term planning for the response;

(b) Multi-year funding commitments to support long-term planning;

(c) Greater coherence with Cosponsors' planning and budgeting cycles;

(d) Reduced transaction costs associated with a two-year planning and budget cycle;

(e) Greater focus on implementation and monitoring of results at the country level.

49. At its 22nd meeting, the PCB endorsed the development of the next UBW, based on a review and extension of the UNAIDS 2007-2010 Strategic Framework to

2011, and confirmed a four-year planning framework and a two-year budget cycle for the UBW. At the 23rd PCB meeting, the Board will consider the revised strategic framework to guide the development of UBW 2010-2011 and also the establishment of a PCB subcommittee on planning and performance monitoring. In June 2009, the 24th PCB will consider approval of the UBW 2010-2011.

V. Second independent evaluation of UNAIDS

50. In December 2007, the 22nd PCB agreed to conduct the Second Independent Evaluation of UNAIDS to assess the efficacy, effectiveness and outcomes of UNAIDS (including UNAIDS Secretariat, the PCB and Cosponsors) at the global, regional and country levels. However, in early 2008, the PCB Bureau decided to suspend the evaluation process in line with the Legal Counsel's advice. Based on the modus operandi of the Programme Coordinating Board, the Bureau's Terms of Reference and the mandate given to it by the 21st Board decision, the Legal Counsel questioned the Bureau's authority on actions taken with regard to the composition of the Oversight Committee of the Second Independent Evaluation of UNAIDS. This Oversight Committee will be tasked with reviewing the evaluation of the work of the UNAIDS family, including the Cosponsors.

51. At the 22nd PCB, the Board agreed that the Cosponsors should have a liaison official who would work with, but not be a member of, the Oversight Committee. The Oversight Committee has ten independent members representing a cross-section of UNAIDS stakeholders. Cosponsors recommended UNFPA to take up the cosponsor liaison role on the committee.

52. The draft report of the Second Independent Evaluation will be presented to the PCB at its 24th meeting in June 2009.

VI. The process for nomination of the Executive Director of UNAIDS

53. At its 22nd meeting, the PCB agreed to create a search committee to oversee the process of nomination of the new Executive Director for UNAIDS. The composition of the search committee includes six member states, two NGOs and four cosponsors (ILO, UNHCR, UNICEF and WHO). Its terms of reference are as follows:

(a) Ensure that the process for submitting nominations and individual applications is duly adhered to;

(b) Encourage and welcome candidates from regions from which an Executive Director of UNAIDS has not yet been appointed;

(c) Develop a scoring tool to evaluate candidates;

(d) Conduct initial interviews to screen candidates and evaluate them against the core competencies and submit qualified candidates in order of preference to the Committee of Cosponsoring Organizations (CCO);

(e) Submit to the chair of the CCO the outcomes of the nomination process in its entirety, including the shortlist of candidates, a report of the process, and a full list of all candidates considered.

54. In the fall of 2008, the CCO — which may also meet in closed session — will consider the list of nominations and interview shortlisted candidates. The chair of the search committee will participate as an observer in the CCO interview and nomination process, and report back to the PCB at its 23rd meeting on the process followed. Finally, the CCO will send a formal nomination to the United Nations Secretary-General.